LIFETIME HEALTH COSTS OF SMOKERS vs. FORMER SMOKERS vs. NONSMOKERS

The best source we have found for estimates of the difference in the average health costs of smokers versus nonsmokers is Hodgson, TA, "Cigarette Smoking and Lifetime Medical Expenditures, *Milbank Quarterly*, 70(1): 81-115, 1992. The following table shows the Hodgson study estimates of the excess average healthcare costs for male and female smokers compared to nonsmokers. Using the current ratio of male to female smokers of 56:44 produces the related weighted averages for all smokers. These estimates are all in 1990 dollars.

Higher Smoker Health Costs (1990 $)	Lifetime
Males	**$8,638**
Females	**$10,119**
Weighted Average	**$9,292**

Updates to the Hodgson Study Estimates

Until more recent estimates worth using are produced, it makes sense to update the Hodgson estimates to account for inflation and to make them more comparable to other smoking-caused healthcare cost estimates that are being used by policymakers, public health advocates, and others. To do that, we follow the example of the U.S. Centers for Disease Control & Prevention (CDC), which recently increased its estimates of state smoking-caused healthcare costs to 2004 dollars using the consumer price index (CPI) for medical care. Using that formula produces the following updated Hodgson estimates in 2004 dollars, with each medical care dollar in 1990 equal to $1.93 in 2004 dollars. [See CDC, *Sustaining State Programs for Tobacco Control: Data Highlights 2006.*] Rounding down is done to be conservative and avoid overstating the health care cost reductions from reducing smoking.

Higher Smoker Health Costs (2004$)	Lifetime	Lifetime – Rounded Down
Males	$16,708	**$16,500**
Females	$19,753	**$19,500**
Weighted Average	$17,973	**$17,500**

Estimates for Former Smokers

The Hodgson study did not provide estimates for the healthcare costs of former smokers -- which must, on average, be somewhere in between the smoker and nonsmoker costs – and we have not found any data specifically on that point. But CDC has published estimates that smokers have a 50% chance of dying from smoking, with former smokers having a 10% to 37% chance. [*MMWR* 45(44): 971-974, http://www.cdc.gov/mmwr/preview/mmwrhtml/00044348.htm, November 8, 1996.] Applying that death-risk ratio to health costs suggests that former smoker's higher health costs would be 10/50 to 37/50 of a smoker's, producing the following estimates.

Higher Smoker Health Costs (2004$)	Lifetime	Lifetime – Rounded Down
Former Smokers Excess Costs	$3,595 - $12,789 (Avg: $8,122)	**$8,000**
Savings from Quitting	$5,185 – $14,378 (Avg: $9,851)	**$9,500**

For related supporting studies, see Nusselder, W., et al., "Smoking and the Compression of Morbidity," E*pidemiology & Community Health*, 2000; Warner, K., et al., "Medical Costs of Smoking in the United States: Estimates, Their Validity, and Their Implications," *Tobacco Control* 8(3): 290-300, Autumn 1999, http://tc.bmjjournals.com/content/vol8/issue3/index.shtml.

January 17, 2008

Total Tobacco Use Prevention and Control Program (TUPCP) funding total = $1,268,998

- **Central Office TUPCP= $186,399**

NOTE: CDC funding administered by TUPCP cannot be used to provide direct services such as individual and group cessation counseling services or to provide direct classroom instruction to students about tobacco cessation.

- Funds 3.75 FTE positions responsible for overall statewide planning, management, operation, and oversight of TUPCP
- Loss of funding will result in loss of 3 FTE positions. No additional funding or staff resources are available to direct to TUPCP

- **Regional Office TUPCP = $446,920**

NOTE: CDC funding administered by TUPCP cannot be used to provide direct services such as individual and group cessation counseling services or to provide direct classroom instruction to students about tobacco cessation.

- Funds 1 FTE position in each of 12 health regions of the state responsible for implementation, monitoring, and evaluation of TUPCP activities including, at a minimum
  - Working with local tobacco coalitions on tobacco control efforts
  - Developing an annual action plan to reduce youth experimentation and use of tobacco
  - Increasing creation of tobacco-free policies within the community
  - Increasing the number of worksites with cessation programs
  - Identifying and eliminating tobacco related health disparities
  - Partnering with other local organizations and chronic disease prevention programs interested in tobacco control
  - Loss of funding will result in loss of 12 FTE positions. No additional funding or staff resources are available to direct to TUPCP

- **TUPCP Contracts = $581,309**
  - Ceridian Lifeworks/Tennessee Tobacco Quitline = $225,000
    - Funds telephonic tobacco use cessation activities including proactive telephone counseling and data collection
    - Loss of funds will result in loss of a readily accessible and effective resource to aid Tennesseans in their efforts to stop smoking, the single most important step they can take to improve their health; and loss of valuable data gathered from Quitline users and used by the Department to formulate best practices for smoking cessation programs taking into account scare resources for funding.

  - Tobacco Technical Assistance Consortium = $57,500
    - Funds development of a CDC required 5 year tobacco strategic plan
    - Loss of funds will result in failure to comply with the CDC requirement to develop a 5 year strategic plan. The Department does

not have the expertise required to produce this document, therefore a contract for services was necessary.

- ❖ Campaign for a Healthy and Responsible Tennessee (CHART) = $175,000
  - ➢ Funds statewide tobacco coalition coordination and advocacy to support tobacco use prevention including developing strategies for environmental changes which support tobacco use prevention and grassroots education for tobacco control policies at local and state level.
  - ➢ Loss of funds will result in inability to provide the CDC TUPCP component related to developing a comprehensive statewide tobacco prevention policy.

- ❖ Unobligated funding for contracts = $123,809

- **Other Funding = $54,370**
  - ➢ Travel = $17,758
  - ➢ Supplies = $4,450
  - ➢ Postage, printing, telephone, etc. = $9421
  - ➢ Indirect Cost = $ 22,741

The US Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), integrated 4 programs into one Collaborative Chronic Disease, Health Promotion, and Surveillance Program that includes:

- Tobacco Control;
- Diabetes Prevention and Control;
- Behavioral Risk Factor Surveillance System; and
- Healthy Communities

This Cooperative Agreement is for a 5 year Project Period beginning March 29, 2009 to March 30, 2014.

The total federal funding for Year 1 for all 4 programs is $1,775,802 of which $1,268,998 is for the Tobacco Control Program.

Matching funds are required from non-federal sources in an amount not less than $1 for each $4 of federal funds awarded. The required level of non-federal participation for Tobacco Control is $317,250.

All 4 programs are funded under one cooperative agreement and must integrate partnerships and collaboration for the purpose of leveraging CDC and state (federal and non-federal) resources to achieve common goals shared by the 4 programs. Without any one of the 4 programs, the entire Cooperative Agreement funding could be in jeopardy.

TN Tobacco QuitLine

- **59.5% of Tennesseans live in a rural area** *(source: Tennessee Dept. of Health; Health Statistics)*
- **15.2% live at or below poverty level (Ranked 9th in the US; US avg. = 12.5%,** *source: Trust for America's Health*)
- **14.4% are uninsured (all ages) (Ranked 20th in the US; US avg 15.3%;** *source: Trust for America's Health http://healthyamericans.org/states/?stateid=TN; date viewed: 06/04/2009*)
- **Adult smoking rates in TN declined from 24.3% in 2007 to 23.1% in 2008**

Smoking is the number one preventable cause of death and illness in Tennessee.
(source: *Centers for Disease Control and Prevention. **Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States, 1995–1999**. Morbidity and Mortality Weekly Report [serial online]. 2002;51(14):300–303 [accessed 2009 Mar 31]*)

SCIENTIFIC EVIDENCE for Quitline
Cochrane Review verbatim: "QuitLine telephone counseling is an evidence-based, effective approach to smoking cessation. Multiple sessions are likely to be most helpful." *(Cochrane Review* – reviewed entire body of scientific literature up through 2006*).* Source*: http://www.cochrane.org/ ;* date viewed 06/04/2009*)*

QuitLine use along with use of a smoking cessation medication doubles the chance of success in quitting the use of tobacco (most effective treatment = counseling + medication). Most efficient method of counseling is telephone, remote counseling.

Effectiveness →
Comparative Cost → Studies have shown that tobacco treatment is more cost-effective than:

- Mammography
- Colonoscopy
- Pap test
- Pharmacologic treatment of mild to moderate hypertension
- Pharmacologic treatment of hypercholesterolemia

(Source: MV Maciosek, AB Coffield et al. Priorities among effective clinical preventative services: results of a systematic review and analysis. *Am J Prev Med* 2006; 31(1).)

TN Tobacco QuitLine

- **QuitLine tracks Smoking Cessation efforts across the state.**
  - Provides Tennessee-specific data on the entire state we would not otherwise have to guide future planning & resource allocations for tobacco cessation.

- **PHYSICIANS & other providers across the state rely on the Quitline to supplement their care for tobacco dependent patients (most tobacco users need 8-10 quit attempts before they are successful; most tobacco**

users need more counseling than the 2-3 minutes allotted in a physician visit).

- Tennessee has a shortage of doctors & nurses which is projected to worsen.
  - Fewer providers in rural areas
  - Providers lack time for extensive counseling many patients need for repeated quit attempts
  - Health care providers/physicians are one of the largest referral source to the TN QuitLine (see below)
  - Quitline is an effective, readily available alternative to in-office counseling by licensed professional staff
  - Available to all Tennesseans, without regard to ability to pay or where they live

▶ **QUITLINE is the <u>most cost-effective</u> treatment**

- Effectiveness → if a caller completes the *iCanQuit* program, the success for quitting averages 37%
- Cost of TN Quitline is $200-1000 per person using the quitline (one-time cost). Range is based on level of use of quitline resources.
  - Heaviest user → cost averages about $83/month
  - Cost of tobacco cessation medication (at whole sale) → heaviest user is $105 to $150/month in medication costs
- Cost of TN Quitline per tobacco user in TN = $0.87/tobacco user in TN
  - TN has 1.5 million tobacco users (smokers); TN has spent since inception $1.3 million → $1.3 million/1.5million smokers = $0.87/tobacco user *(source: Tennessee Dept of Health, BRFSS 2007-2008)*
- Direct lifetime cost savings due to quitting = **$16,000 per quitter** (cost adjusted from 1992 to year 2002 dollars; source: Hodgson, TA; Cigarette Smoking and Lifetime Medical Expenditures, Milbank Quarterly, 70(1):81-115, 1992)
  - Additional work has been done (attached with references) to convert to 2004 dollars (source: <u>http://www.tobaccofreekids.org/research/factsheets/pdf/0277.pdf</u>; date viewed: 06/04/2009)

▶ **Estimated direct savings due to the TN QuitLine:**

- **Return on Investment (conservative estimate) = $2.89 for every $1 spent thus far → this return on investment does NOT include savings due to lost productivity of Tennessee workforce due to tobacco**
  - Accepted number of $16,000/person in life-time health care cost savings if a tobacco user quits (referenced above)
  - How is the estimate calculated → Using the TN QUITLINE data of the number of tobacco users who are quit at 3mos, 6mos, 9mos, and 12mos and the scientific evidence that estimates the likelihood of being a lifetime quitter in addition to the accepted life-time health care savings per quitter ($16,000 per quitter), the ROI = 2.89 to 1

▶ **Productivity losses due to smoking**

- **Smokers are less productive than non-smokers**

- **Miss work 2-7 days more/per year for illnesses than non-smokers** (based on analysis of 25 studies).
- With a national average tobacco-use prevalence of 20%, a company of 10,000 employees and their eligible dependents is incurring an estimated $14,188,840 per year in excess costs (both health care related costs and lost productivity) associated with smoking. (Katie Rodgers, "The hazards of secondhand smoke," "Business & Health Special Report, Vol. 15, No. 8, summer, 1997, p. 5.)

▶ **Who is reached with the QuitLine?**

- 27,422 people have called the TN QuitLine in Tennessee since started on August 3, 2006
- 6,242 callers have enrolled into the ***iCanQuit*** tobacco cessation program
- Callers are from all 95 counties in TN
- Most (about 75%) are of the age 25-54 years old (working age group – **less likely to take time from work to seek care due to work & family obligations)**
  - **Extends effective care to uninsured**
  - **Extends effective care to under-insured (not covered by most insurance policies)**

▶ **How do people know about the TN QuitLine?**

- Top 5 referral sources are
  - Health Dept. Tobacco Cessation Program
  - TV advertisements
  - Physician/Health Care Provider
  - Spouse/Family Member
  - Brochures

Office on Smoking and Health

Technical Assistance Document

National Tobacco Control Program

As the lead Federal agency with responsibility for comprehensive tobacco prevention and control, the Centers for Disease Control and Prevention's (CDC) Office on Smoking and Health (OSH) maintains the National Tobacco Control Program (NTCP) to decrease the major preventable cause of death in the U.S. and protect the public's health from the harmful effects of tobacco use. The NTCP includes every state, the District of Columbia, as well as Pacific and Caribbean territories and jurisdictions, National Networks, Tribal Support Centers, and non-governmental organizations.

Recipient Activities

A) Administration, Management, and Leadership

1. Strategic Planning

Develop a five-year strategic plan, or update an existing multi-year strategic plan that spans the proposed funding cycle, with active participation of a diverse group of stakeholders including state and community partners, Tribes and Tribal organizations, representatives from multiple ethnicities, geographic and professional areas. State health departments that do not have primary responsibility for the overall state strategic plan should actively participate in the state strategic planning process. The plan should explain the program to others in order to inform, motivate, and involve. The strategic plan should: be based on data gained from state surveillance and other data gathering efforts, including an environmental scan; form the basis of the workplans for the statewide and local contracts and grants to ensure the program is working strategically and in a focused manner to achieve its goals; serve as a framework for decisions on annual programmatic direction; provide a foundation for the development of Annual Action Plans that include appropriate programmatic components and interventions that support the outcome objectives identified in the plan; identify and provide support for addressing areas of tobacco-related disparities and incorporate the disparities plan as appropriate; incorporate sustainability measures from the state sustainability plan, if applicable; complement other state chronic disease prevention and health promotion programs to reduce tobacco-related chronic diseases; include a schedule for annual review to revise programmatic direction as appropriate.

Performance will be measured by evidence that a five-year, evidence based and data-supported strategic state tobacco control plan has been developed and will be reviewed and updated as determined by changes in the state tobacco control environment.

Evidence can be shown by a description of how the plan was developed that includes elements described above. State health departments that do not have primary responsibility for the overall state strategic plan should provide evidence of participation in the planning process and clear role delineation with other agencies.

2. Leadership and Collaboration

Develop and maintain statewide and local active partnerships that support the goal of reducing or eliminating the health and economic burden of tobacco use, and implement an effective communication system with partners at the state and local level. Partnerships may include chronic disease and health promotion programs within health departments, statewide and local organizations, voluntary health organizations, universities, local health departments, organizations that represent diverse communities, National Networks, American Indian/Alaska Native Tribes and organizations that represent Tribes, Tribal Support Centers, community based organizations, other state agencies whose mission is tobacco control, statewide and local coalitions, and boards, commissions, and advisory groups with responsibility for the state tobacco control program. Working with partners includes capacity building with those organizations through technical assistance, training and educational activities, as well as collaboration on implementing evidence-based interventions.

Performance will be measured by accomplishment of the activities described above in item, "Leadership and Collaboration."

Evidence can be shown by submission of 5-10 letters of collaboration that clearly define the role and level of commitment from the local and state partner organization; descriptions of active participation in statewide and community conference planning, training, and media campaigns; descriptions of efforts to expand partnerships; descriptions of collaborations with statewide and community partners to build capacity and implement evidence-based interventions; indications that the state coalition is representative of the state's population; descriptions of plans to maintain and strengthen participation by groups identified as experiencing tobacco-related health disparities, evidence of participation of diverse groups in program activities.

3. Training, Technical Assistance, and Consultation

Develop and implement a coordinated plan to assess and address the needs of state and local health department staff, coalitions, Tribes and Tribal organizations, and partners involved in tobacco prevention and control activities.

Performance will be measured by:

Evidence that training and technical assistance needs have been assessed and provided by the program to local and state health department staff, coalitions, and partners. Evidence can be shown by: description of a training plan that includes the strategic purpose of the trainings and anticipated outcomes; descriptions of trainings planned and provided; feedback from the trainings and technical assistance; description of the process and strategy to provide technical assistance and consultation.

4. Coordination of Efforts among Chronic Disease Prevention and Health Promotion Programs

Refer to the FOA and the Guidance Document for information about Coordination of Efforts among Chronic Disease Prevention and Health Promotion Programs.

5. Information Exchange

Develop and implement mechanisms to facilitate information exchange between the state Tobacco Control Program, the CDC, tobacco control program staff in other states, and national partners.

Refer to the FOA for further information about Information Exchange.

Performance will be also measured by evidence of active participation in the Tobacco Control Network, the North American Quitline Consortium, national and regional conference planning committees, and other tobacco control national organizations and working groups.

6. Sustainability

Refer to the FOA for information about Sustainability.

7. Program Management

a. Staffing. Identify and hire staff with the appropriate competencies to manage a tobacco prevention and control program and provide information to demonstrate that management staff are at a level within the agency to affect the decision making process related to the tobacco control program.

A full-time program manager to administer the program is required. A recommended minimum number of staff is seven FTEs including the Program Manager and one FTE for administrative support. Funding from other sources increases the scope of the program, requiring additional staff to administer and monitor the program. A

recommended number of staff based on increased funding levels is an additional one to eight FTEs for a total of eight to sixteen FTEs with program justification including description of activities funded through other sources.

Staff should have knowledge and skills in: program development, coordination and management; fiscal management including management of funding to state and community partners; leadership development; tobacco control and prevention content; cultural competence; public health policy including analysis, development and implementation; community outreach and mobilization; training and technical assistance, health communications including counter-marketing; strategic use of media including media advocacy, earned and paid media; strategic planning; gathering and analyzing data; evaluation methods, cessation strategies and quitline management; health care systems changes; identification and elimination of tobacco-related health disparities; expertise in working with diverse populations. Staff should reflect the diversity of the state's population.

The Program Manager and the administrative support position should be FTEs within the State Health Department (SHD). Other positions may be SHD FTEs or contractual.

Performance will be measured by evidence that the SHD has dedicated human resources to administer and manage the program effectively consistent with the competencies and staffing levels identified above.

Evidence of the provision of ongoing training for staff can be demonstrated through staff participation in CDC sponsored training, meetings, conferences and other continuing education opportunities as identified by SHD program staff.

Evidence of organizational impact can be demonstrated by describing how management staff has organizational access to the State Health Officer and by providing information on senior level management involvement in the tobacco control program.

b. Fiscal Management

1. Use funding to support state and local programs that focus on population-based strategies that are science-based and policy-focused and reach diverse groups.

2. Develop and maintain systems for sound fiscal management.

Performance will be measured by evidence that the SHD activities resulted in accomplishment of items (a), (b) above.

See the FOA for more information about Fiscal Management.

c. Attendance at Training Sessions/Conferences

Staff is expected to travel to the following conferences in 2009-2010:

Conference	No. Staff	No. Days	Location
1. Best Practices/Program Indicators/Media	2	2	Atlanta, GA
2. National Tobacco Control Program	2	2	Phoenix, AZ
3. National Conference on Tobacco or Health (NCTOH)	3	3	Phoenix, AZ

The National Tobacco Control Program, along with several ancillary meetings, will be held just prior to the National Conference on Tobacco or Health in Phoenix, AZ.

States can request that CDC cover the travel costs of out-of-state trainings and meetings for up to three staff per required meeting or conference. If a state program elects to have CDC cover travel costs, clearly state that the program is electing this option and provide an estimated expense for travel. Under this arrangement, the state award will be reduced by the amount estimated for travel plus an additional administrative cost.

B) Surveillance, Analyses, and Evaluation:

Tobacco control programs will be funded to conduct surveillance, analyses, and evaluation that complement the surveillance conducted by the BRFSS.

Develop and implement an evaluation plan with stakeholders' involvement. The evaluation plan should include clear goal-based logic models, with outputs, short, intermediate, and long-term objectives. The evaluation plan should clearly describe efforts to collect key tobacco-related indicators, including data collection timetables, valid data collection methods that are comparable across states, and the method to track the number and type of policy and systems changes that support the NTCP goal areas. The plan should also address the production, dissemination, and utilization of evaluation reports.

Collaborate with CDC to administer the National Adult Tobacco Survey and Youth Tobacco Survey and to collect specific indicators to serve as a baseline for year one of the Award and to measure progress at followup.

Performance will be measured by accomplishment of the activities described above by providing the following evidence: A description of a comprehensive evaluation plan, including the involvement of stakeholders in the evaluation planning process; recommendations made and/or actions taken by diverse state and local stakeholders, such as an advisory group or task force; a description of the data collection activities, including methodologies and data analysis; a description of process and outcome objectives and indicators to be used in program evaluation; a description of the SHD's role in coordinating surveillance and evaluation efforts and providing technical assistance and training on program monitoring, data collection, and evaluation; the production and

dissemination of useful evaluation reports, and the utilization of evaluation findings to improve, expand, or maintain the tobacco control program.

C) Promoting Social, Environmental, Policy, and Systems Approaches at the State and Community Levels

1. Local grant programs. Establish state and local programs to work toward policy goals in support of the four CDC National Tobacco Control Program goal areas. Support local programs to establish grassroots networks at the community level and with Tribes or Tribal organizations to develop evidence-based tobacco control activities and participate in a state-developed standardized grants reporting system. Support should be sufficient for designated staff at the community level to establish and participate in coalitions, partnerships, and task forces for local policy development and implementation and counter-marketing efforts; conduct a local environmental scan; develop and implement plan consistent with the state strategic plan; participate in state evaluation and data collection efforts; take part in sustainability efforts; and access tobacco control information through a variety of sources such as journals, Web sites, and list serves. Refer to U.S. HHS, CDC's *Best Practices for Comprehensive Tobacco Control Programs, October* 2007, and the *Guide to Community Preventive Services*: *Tobacco Use Prevention and Control*, February 2001 for information about local programs.

Performance will be measured by accomplishment of the activities described above.

2. Prevent initiation of tobacco use. Develop and implement science-based policy-focused strategies identified in the state strategic plan to prevent youth initiation of tobacco use.

Performance will be measured by accomplishment of the activities described above in "Prevent Initiation to Tobacco Use Among Young People." Evidence can be shown by describing: Strategies to promote evidence-based interventions, including those found in *Guide to Community Preventive Services* and CDC's *Best Practices for Comprehensive Tobacco Control Programs*; multi-component community interventions to reduce youth initiation that are science-based and policy focused such as price increases for tobacco products; educational activities that address the efficacy of policy initiatives such as restrictions on tobacco advertising, promotion and sponsorships; identification of disparities related to youth initiation and susceptibility to tobacco use, including exposure to pro- and anti- tobacco marketing, exposure to secondhand smoke, and other factors; strategies to reduce identified disparities; comprehensive tobacco-free school policies and partnerships with state and local education organizations to promote CDC "Guidelines for School Health Programs to Prevent Tobacco Use and Addiction;" communication strategies that include media advocacy and paid advertising to disseminate messages regarding youth tobacco use; pro-health messages.

3. Eliminate exposure to secondhand smoke. Develop and implement science-based policy-focused strategies identified in the state strategic plan to eliminate exposure to secondhand smoke.

Performance will be measured by accomplishment of the activities described above in item, "Eliminate Exposure to Secondhand Smoke."

Evidence can be shown by describing: Strategies to promote evidence-based interventions, including those found in the *Guide to Community Preventive Services* and CDC's *Best Practices for Comprehensive Tobacco Control Programs*; strategies to

reduce identified disparities; plans and actions to educate the public on the need for eliminating secondhand smoke exposure; science-based strategies to promote smoke-free policies at the local or state level or on a voluntary basis where other options are not possible; strategies to maintain or restore local control over smoking restrictions; efforts to educate the public concerning laws and regulations eliminating secondhand smoke and to implement those laws as appropriate.

4. **Promote cessation among adults and youth.** Implement science-based policy-focused strategies to promote cessation among adults and youth.

Evidence can be shown by describing:

Strategies to promote evidence-based interventions, including those found in *Guide to Community Preventive Services: Tobacco Use Prevention and Control,* CDC's *Best Practices for Comprehensive Tobacco Control Programs,* and the Public Health Service Clinical Practice Guideline *Treating Tobacco Use and Dependence: 2008 Update;* strategies to reduce identified disparities; communication strategies that incorporate earned and paid media to provide information about and motivation for quitting and reach diverse populations and populations disproportionately impacted by tobacco use; statewide and community activities that support policy development and initiatives that promote cessation, such as smoke-free policies and increased tobacco product prices; links between the state program, other health department programs, and other organizations to support and promote cessation.

Information about quitlines and health care system changes, including insurance coverage, can be found in Section E), Interventions to Improve Health Care systems.

5. Identify and eliminate tobacco-related health disparities. Identify and eliminate disparities in specific population groups related to 1) preventing initiation among young people; 2) eliminating exposure to secondhand smoke; and 3) promoting cessation among adults and youth.

Performance will be measured by accomplishment of activities in item "Identify and eliminate tobacco-related health disparities."

Evidence can be shown by: convening a diverse and inclusive stakeholders group; developing a system for receiving input from stakeholders to aid in identification and elimination of disparities; identifying and reporting baseline information on populations with tobacco-related disparities using both quantitative and qualitative methods; assessing national data sources and research related to at-risk populations; coordinating available state and national data with at-risk populations in the state; examining the potential limitations of data used; identifying and developing innovative qualitative and quantitative-based methodologies for data collection among specific population groups to augment state data (e.g. conduct a qualitative and quantitative demographic profile, conduct an environmental scan to identify disparities); developing a strategic plan that includes implementation strategies and evaluation components for tobacco-related disparities; integrating the plan into the overall state strategic plan; integrating the evaluation components into the overall program evaluation plan; building capacity of grantees and partners at the state and local levels to maintain an infrastructure to implement culturally competent interventions, prevention programs and communication strategies (e.g., provide cultural competency training and technical assistance and resource materials and tools for working with specific populations); reporting on

evaluation strategies and indicators to measure the impact of culturally tailored interventions in the three goal areas to eliminate tobacco-related disparities (e.g., describe target populations, what was done, where, when, methods, and outcomes or impact).

D) Health Communications Interventions

Develop and maintain an effective communication system and communication plan to share information on a regular basis and as needed with partners, the media, and the public. The communication system and plan should use a variety of media, channels, and communication techniques throughout the year. Communication should be strategic, culturally competent, and integrated into the larger tobacco control program to prevent initiation of tobacco use among young people, eliminate exposure to secondhand smoke, promote cessation among adults and youth, and eliminate tobacco-related disparities among specific populations. It should include evaluation, such as formative, process, and outcome.

Performance will be measured by evidence of a communication plan that incorporates the activities described above.

E) Interventions to Improve Health Care Systems

Tobacco Control Programs will be funded to sustain existing tobacco cessation quitlines and implement changes in health care systems recommended by the 2008 update of the Clinical Practice Guideline.

a. Quitlines. The 2008 PHS Guideline and the *Guide to Community Preventive Services* both recommend proactive telephone counseling as a method to aid in tobacco use cessation.

States are expected to sustain existing state tobacco cessation quitline services linked to the 1-800-QUIT NOW portal as part of the overall cessation goal area.
Identify and secure other funding sources for the quitline; convene a consortium of key stakeholders to garner future non-federal financial support for the quitline. Improve or expand quitline services by increasing proactive counseling capacity, extending hours of services, adding multiple language services, revising counseling protocols or otherwise improving the quality of services based on feedback from the quitline evaluation and other sources. Expand marketing efforts to promote awareness and use of the quitline, including outreach to populations with tobacco-related disparities. Increase collaboration with healthcare systems and providers. Collect the Minimum Data Set, as defined by the North American Quitline Consortium. Evaluate the state quitline. Maintain active membership in the North American Quitline Consortium. Participate in continuing education activities related to quitline services and evaluation.

Collaborate with the state Diabetes Program and other chronic disease prevention and health promotion programs as appropriate to promote use of the quitline to persons diagnosed with diabetes who use tobacco products and their health care providers.
Performance will measured by evidence of the activities described above.
Evidence can be shown by:

Description of how the quitline is part of the overall cessation goal area.

Description of the current quitline service in the state (vendor, eligibility, medication provided, hours of service, languages offered, phone number used).

Description of how CDC funds will be used to sustain, enhance, promote, or evaluate tobacco cessation quitline services.

Descriptions of efforts to promote the quitline, including paid and earned media, fax referral systems, NRT support, or other state and community-based promotions and outreach to populations with tobacco-related disparities.

Descriptions of collaborations with other states, national partners, Tribes and Tribal organizations, and other CDC-sponsored Chronic Disease Prevention and Health Promotion Programs, including the Diabetes Program to enhance, promote, or evaluate the quitline.

Description of participation in the North American Quitline Consortium.

Description of current surveillance and evaluation, types of data collected.

Indication of whether the state collects the Minimum Data Set (MDS), and if not, plans to collect the MDS.

Report the following information on the quitline:

- Number of callers in the past 12 months
- Number of callers receiving counseling in the past 12 months, by demographic group
- Percentage of smokers calling the quitline
- Quit rate calculated using NAQC/CDC recommendations

b. Health care systems changes. Support making the health system changes recommended by the PHS Clinical Practice Guideline, including implementing a system of tobacco use screening and documentation to increase provider intervention, linking tobacco users to quitlines or other cessation services, and covering treatment costs for tobacco use cessation under public and private insurance, including individual, group, and telephone counseling and all FDA-approved medications. Promote awareness and

use of existing tobacco cessation insurance. Support elimination of cost and other barriers to treatment, particularly for underserved populations, the uninsured, and populations disproportionately affected by tobacco use.

Performance will be measured by evidence of the activities described above.

V.1. Criteria
Evaluation Criteria

Project Abstract. Not scored.

Background and Need (**10 points**). The extent to which the applicant justifies the need for this program, including whether sufficient information is provided to describe the state's environment, major events in the state, barriers, and plans to overcome barriers.

Workplan (**75 points**)

Annual Action Plan (**5 points**). The extent to which the annual action plan is based on the strategic plan, builds on the needs described in the Background and Needs sections, and includes activities in line with Recipient Activities and Application Content. See pages 17-19.

A) Administration, Management, and Leadership (30 points)

B) Surveillance, Analyses, and Evaluation (10 points)

C) Promoting Social, Environmental, Policy, and Systems Approaches at the State and Community Levels (15 points)

D. Health Communications Interventions (4 points)

E. Interventions to Improve Health Care Systems (11 points)

Accomplishments and Proven Capacity (**15 points**)

Budget and Justification. Reviewed, but not scored.

Annual Action Plan Guidance

Annual Action Plans should include annual objectives and activities that:

- Link to relevant short, intermediate, or long-term outcome objectives that correspond to evidence-based logic models. (See Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs - KOI);
- Are aimed at developing or improving required program infrastructure as outlined in the Administration, Management, and Leadership; and Surveillance, Analysis, and Evaluation sections of this document;
- Address the three intervention focus areas described in this document (1. Promoting Social, Environmental, Policy, and Systems Approaches at the State and Community Level, 2. Health Communication Interventions, and 3. Health Care Systems Interventions);
- Reflect those parts of the overall state strategic plan for which the Tobacco Control Program has lead responsibility; and
- Are shared across chronic disease programs.

The AAP should include the following information:

1. Program goal area(s)
    - The program goal should identify the purpose toward which a series of coordinated objectives and activities that follow are directed.
    - Tobacco Control Programs should work in all four NTCP goal areas: 1. Prevent initiation of tobacco use; 2. Eliminate exposure to secondhand smoke; 3. Promote cessation among youth and adults; 4. Identify and eliminate tobacco-related health disparities.
    - More than one goal may be listed together on the AAP if they are related and being addressed by the same set of objectives and activities.

1. Long-term Outcome Objective(s)
    - Long-term outcome objectives should cover the 5-year funding period.
    - Long-term outcome objectives should be associated with an evidence-based indicator as listed in the Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs.
    - Long term outcome objectives should be SMART* and should describe things such as a lasting change in behavior regarding tobacco use or exposure to secondhand smoke, reduced consumption, reductions in morbidity and mortality (if appropriate over a 5-year period), or a reduction in tobacco-related disparities. Indicator numbers, where possible, should be included at the end of the objective statement. Example:
        - By March, 2014, the percent of state residents who use tobacco will be reduced to 15% from a 2007 baseline of 18.4%. (3.14.1)

- More than one long-term outcome objective may be listed if they are related and address the same program goal areas. If more than one long-term outcome objective is listed, number each objective.
- Identify the program(s) involved in meeting each long-term objective [e.g., Diabetes, BRFSS, Tobacco Control, Healthy Communities, Other (specify)].
- Identify the data source(s) that will be used to measure progress on each long-term objective (e.g., Youth Tobacco Survey; state policy tracking).

Optional: To demonstrate the full scope of the initiatives your program intends to pursue over the course of the Cooperative Agreement, your program may find it helpful to include SMART intermediate and short-term outcome objectives that are consistent with the logic pathways outlined in the KOI Report. Please include information similar to that which is discussed for long-term objectives.

2. Annual objective(s)
   - SMART objectives that quantify the results of one or more program activities that will be completed within a 12-month funding period.
     Example:
     - By March 31, 2010, 200 health care provider organizations who serve patients with diabetes will have increased knowledge about the availability and efficacy of tobacco cessation services through the state quitline. (Collaborative Example)
     - By March 31, 2010, 51% state-level policy makers and 30 influential community leaders will publically demonstrate support for an increase in the state tobacco excise tax.
   - Annual objectives may change each year.
   - More than one annual objective may be listed if they are related and address the same long-term outcome objective. If more than one annual objective is listed, number them.
   - Identify the program(s) involved in meeting each annual objective [e.g., Diabetes, BRFSS, Tobacco Control, Healthy Communities, Other (specify)].
   - Identify the data source(s) that will be used to measure progress on each annual objective (e.g., NCI tracking of state calls to 1-800-QUIT NOW).

3. Rationale
   - If an outcome objective is not associated with an evidence-based indicator, provide a description of how the objective was selected and how it will lead to the accomplishment of the long-term objective. The rationale should include the following three components:
     i. What is the problem being addressed?
     ii. What is the evidence (including data) indicating that this is a problem worth addressing?
     iii. What is the evidence (including data) that this objective(s) will address the problem?

4. Activities
    - Activities are events or actions that a program implements to achieve an objective. Activities should support the accomplishment of the annual objectives.
    - Up to four high-level activities should be identified to describe the most significant things (not simply the day-to-day activities of the program) the funded program will do to meet the annual objective(s). (Please indicate the annual objective number that is being supported by the activity, if appropriate, in the following manner "Activity #.#")
    - Activities may be confined to one program or may reflect collaborative efforts.

        Example:
        Activity 1.1: Develop and secure the placement of 4 journal inserts for both the state Medical Association and the Journal of the American Diabetes Association promoting the efficacy of population-based cessation services, the state quitline and the 1-800-QUIT-NOW portal.
        Activity 1.2: All state Diabetes Educators, Tobacco Educators, DACH Community Health staff and BRFSS evaluation professionals will attend a training sponsored by the state tobacco quitline that will provide an orientation and update on services available through the state quitline and the efficacy of services.
        Activity 2.1: Through a contractor, conduct pre-intervention assessments of positions to identify elected officials for outreach and education about the need for a tobacco tax increase with dedication for tobacco control and chronic disease prevention.
        Activity 2.2: Train 100 state and community tobacco, diabetes and other coalition members around community advocacy for the purposes of identifying and educating 100 influential community leaders about the need for a dedicated tobacco tax increase. Particular emphasis will be placed on identifying influential leaders from communities of color.

    - Each activity must also include a target date for completion, the funding source(s), and partner(s) involved (up to four).
        - Target Date: The date the activity is expected to be completed.
        - Funding Sources: Identify which CDC- or state-funded programs are contributing resources (monetary or in-kind) to the accomplishment of the activity.
        - Partners: Identify up to four key partners involved in the activity.

*SMART objectives are Specific, Measurable, Achievable and ambitious, Relevant and realistic, and Time-bound. When writing a SMART objective, identify the following:

- Target date for completion.
- Baseline measure.
- Target measure.
- Population specifics, including race, ethnicity, sex, and age.

- Setting, such as community, health care, faith-based, school, worksite, and government.